Complete Summary

GUIDELINE TITLE

Recommended childhood and adolescent immunization schedule: United States, 2006.

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatrics, Committee on Infectious Disease. Recommended childhood and adolescent immunization schedule--United States, 2006. Pediatrics 2006 Jan;117(1):239-40. PubMed

Centers for Disease Control and Prevention (CDC). Recommended childhood and adolescent immunization schedule -- United States, 2006. MMWR Morb Mortal Wkly Rep 2006 Jan 6;54(51&52):Q1-4. [5 references]

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Recommended childhood and adolescent immunization schedule - United States. MMWR Morb Mortal Wkly Rep 2005 Jan 7;53(51):Q1-3.

Recommended childhood and adolescent immunization schedule--United States, 2005. Pediatrics 2005 Jan;115(1):182.

COMPLETE SUMMARY CONTENT

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SCOPE

DISEASE/CONDITION(S)

Vaccine-preventable diseases:

- Diphtheria
- Hepatitis A and B
- Haemophilus influenzae infection
- Influenza
- Measles
- Meningococcal disease
- Mumps
- Pertussis
- Pneumococcal infection
- Polio
- Rubella
- Tetanus
- Varicella (chickenpox)

GUIDELINE CATEGORY

Prevention

CLINICAL SPECIALTY

Family Practice
Infectious Diseases
Pediatrics
Preventive Medicine

INTENDED USERS

Advanced Practice Nurses
Health Care Providers
Nurses
Physician Assistants
Physicians
Public Health Departments

GUIDELINE OBJECTIVE(S)

- To ensure that the recommended childhood and adolescent immunization schedule is current with changes in vaccine formulations
- To reflect revised recommendations for the use of licensed vaccines, including those newly licensed

TARGET POPULATION

Children and adolescents through 18 years residing in the United States

INTERVENTIONS AND PRACTICES CONSIDERED

Immunization with the following vaccines:

1. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP/Tdap/Td)

2. Haemophilus influenzae type b (Hib) conjugate
3. Hepatitis A and B (HepA and HepB) vaccine
4. Inactivated polio virus (IPV)
5. Influenza vaccine
    - Intramuscular trivalent inactivated influenza vaccine (TIV)
    - Live-attenuated influenza vaccine (LAIV)
6. Measles, mumps and rubella (MMR) vaccine
7. Meningococcal vaccine
    - Meningococcal conjugate vaccine (MCV4)
    - Meningococcal polysaccharide vaccine (MPSV4)
8. Pneumococcus
    - Pneumococcal conjugate vaccine (PCV)
    - Pneumococcal polysaccharide vaccine (PPV)
9. Varicella vaccine (VAR)

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Not stated

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

The recommendations and format of the childhood and adolescent immunization schedule and catch-up schedule for January-December 2006 were approved by the Advisory Committee on Immunization Practices (ACIP), the American Academy of Pediatrics (AAP), and the American Academy of Family Physicians (AAFP).

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Note from the National Guideline Clearinghouse (NGC): The guideline recommendations are presented in the form of tables with footnotes (see below).The changes to the previous childhood and adolescent immunization schedule, published January 2005, are as follows:

- The importance of the hepatitis B vaccine (HepB) birth dose has been emphasized. Vaccination of infants born to hepatitis B surface antigen (HBsAg)-negative mothers can be delayed in rare circumstances, but only if a physician's order to withhold the vaccine and a copy of the mother's original HBsAg-negative laboratory report are documented in the infant's medical record. Administering four doses of HepB is permissible (e.g., when combination vaccines are administered after the birth dose); however, if monovalent HepB is used, a dose at age 4 months is not needed. For infants born to HBsAg-positive mothers, testing for HBsAg and antibody to HBsAg after completion of the vaccine series should be conducted at age 9-18 months (generally at the next well-child visit after completion of the vaccine series).
- A new tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine recommended by the Advisory Committee on Immunization Practices (ACIP) for adolescents (Tdap adolescent preparation) was approved by the U.S. Food and Drug Administration (FDA) on May 5, 2005, for use in the

United States. Tdap is recommended for adolescents aged 11-12 years who have completed the recommended childhood diphtheria and tetanus toxoids and pertussis/diphtheria and tetanus toxoids and acellular pertusis (DTP/DTaP) vaccination series and have not received a tetanus and diphtheria toxoids (Td) booster dose. Adolescents aged 13-18 years who missed the age 11-12--year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series. Subsequent Td boosters are recommended every 10 years.

- Meningococcal conjugate vaccine (MCV4), approved by the FDA on January 14, 2005, should be administered to all children at age 11-12 years as well as to unvaccinated adolescents at high school entry (age 15 years). Other adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated. All college freshmen living in dormitories should also be vaccinated with MCV4 or meningococcal polysaccharide vaccine (MPSV4). For prevention of invasive meningococcal disease, vaccination with MPSV4 for children aged 2-10 years and with MCV4 for older children in certain high-risk groups is recommended.
- Influenza vaccine is now recommended for children aged $\geq$6 months with certain risk factors, which now specifically include conditions that can compromise respiratory function or handling of respiratory secretions or that can increase the risk for aspiration.
- Hepatitis A vaccine is now universally recommended for all children at age 1 year (12-23 months). The 2 doses in the series should be administered at least 6 months apart.
- The catch-up schedule for persons aged 7-18 years has been changed for Td; Tdap may be substituted for any dose in a primary catch-up series or as a booster if age appropriate for Tdap. A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose.

Vaccine Information Statements

The National Childhood Vaccine Injury Act requires that health-care providers provide parents or patients with copies of Vaccine Information Statements before administering each dose of the vaccines listed in the schedule. Additional information is available from state health departments and from the Centers for Disease Control and Prevention (CDC) at http://www.cdc.gov/nip/publications/vis.

Detailed recommendations for using vaccines are available from package inserts, ACIP statements on specific vaccines, and the 2003 Red Book. ACIP statements for each recommended childhood vaccine are available at the CDC National Immunization Program website at http://www.cdc.gov/nip/publications/acip-list.htm. In addition, guidance for obtaining and completing a Vaccine Adverse Event Reporting System form is available at http://www.vaers.hhs.gov or by telephone, 800-822-7967.

Recommended childhood and adolescent immunization schedule -- United States, 2006

Vaccine	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	24 months	4-6 years

Hepatitis B[1]	HepB	HepB		HepB[1]	HepB					
Diphtheria, Tetanus, Pertussis[2]			DTaP	DTaP	DTaP		DTaP			DTaP
Haemophilus influenzae type b[3]			Hib	Hib	Hib[3]	Hib				
Inactivated Poliovirus			IPV	IPV	IPV					IPV
Measles, Mumps, Rubella[4]						MMR				MMR
Varicella[5]						Varicella				
Meningococcal[6]										
Pneumococcal[7]			PCV	PCV	PCV	PCV				
Influenza[8]					Influenza (yearly)					
Hepatitis A[9]						HepA Series				
Vaccines below this line are for selected populations										
Meningococcal[6]									MPSV4	
Pneumococcal[7]									PCV	
Influenza[8]									Inf	
Hepatitis A[9]										

Range of recommended ages | Catch-up vaccination | Assessment at age 11-12 years

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2005, for children through age 18 years. Any dose not administered at the recommended age should be administered at any subsequent visit when indicated and feasible.

Green shaded regions of the table (also indicated by an *) indicate age groups that warrant special effort to administer those vaccines not previously administered. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and the other components of the vaccine are not contraindicated and if approved by the U.S. Food and Drug Administration (FDA) for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices (ACIP) statements for detailed recommendations. Clinically significant adverse events that follow vaccination should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). AT BIRTH: All newborns should receive monovalent HepB soon after birth and before hospital discharge. Infants

born to mothers who are hepatitis B surface antigen (HBsAg)-positive should receive HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth. Infants born to mothers whose HBsAg status is unknown should receive HepB within 12 hours of birth. The mother should have blood drawn as soon as possible to determine her HBsAg status; if HBsAg-positive, the infant should receive HBIG as soon as possible (no later than age 1 week). For infants born to HBsAg-negative mothers, the birth dose can be delayed in rare circumstances but only if a physician's order to withhold the vaccine and a copy of the mother's original HBsAgnegative laboratory report are documented in the infant's medical record. FOLLOWING THE BIRTH DOSE: The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1-2 months. The final dose should be administered at age ≥24 weeks. Administering four doses of HepB is permissible (e.g., when combination vaccines are administered after the birth dose); however, if monovalent HepB is used, a dose at age 4 months is not needed. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of the HepB series at age 9-18 months (generally at the next well-child visit after completion of the vaccine series).

2. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. The final dose in the series should be administered at age ≥4 years. Tetanus toxoid, reduced diphtheria toxoid, and acellular pertussis vaccine (Tdap adolescent preparation) is recommended at age 11-12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids (Td) booster dose. Adolescents aged 13-18 years who missed the age 11-12--year Td/Tdap booster dose should also receive a single dose of Tdap if they have completed the recommended childhood DTP/DTaP vaccination series. Subsequent Td boosters are recommended every 10 years.
3. Haemophilus influenzae type b conjugate vaccine (Hib). Three Hib conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required. DTaP/Hib combination products should not be used for primary immunization in infants at ages 2, 4, or 6 months but may be used as boosters after any Hib vaccine. The final dose in the series should be administered at age ≥12 months.
4. Measles, mumps, and rubella vaccine (MMR). The second dose of MMR is recommended routinely at age 4-6 years but may be administered during any visit, provided at least 4 weeks have elapsed since the first dose and both doses are administered at or after age 12 months. Children who have not previously received the second dose should complete the schedule by age 11-12 years.
5. Varicella vaccine. Varicella vaccine is recommended at any visit at or after age 12 months for susceptible children (i.e., those who lack a reliable history of varicella). Susceptible persons aged ≥13 years should receive 2 doses administered at least 4 weeks apart.
6. Meningococcal vaccine (MCV4). Meningococcal conjugate vaccine (MCV4) should be administered to all children at age 11-12 years as well as to unvaccinated adolescents at high school entry (age 15 years). Other

adolescents who wish to decrease their risk for meningococcal disease may also be vaccinated. All college freshmen living in dormitories should also be vaccinated, preferably with MCV4, although meningococcal polysaccharide vaccine (MPSV4) is an acceptable alternative. Vaccination against invasive meningococcal disease is recommended for children and adolescents aged ≥2 years with terminal complement deficiencies or anatomic or functional asplenia and for certain other high risk groups (see the NGC summary Prevention and control of meningococcal disease); use MPSV4 for children aged 2-10 years and MCV4 for older children, although MPSV4 is an acceptable alternative.

7. Pneumococcal vaccine. The heptavalent pneumococcal conjugate vaccine (PCV) is recommended for all children aged 2-23 months and for certain children aged 24-59 months. The final dose in the series should be administered at age ≥12 months. Pneumococcal polysaccharide vaccine (PPV) is recommended in addition to PCV for certain high-risk groups.
8. Influenza vaccine. Influenza vaccine is recommended annually for children aged ≥6 months with certain risk factors (including, but not limited to, asthma, cardiac disease, sickle cell disease, human immunodeficiency virus infection, diabetes, and conditions that can compromise respiratory function or handling of respiratory secretions or that can increase the risk for aspiration), health-care workers, and other persons (including household members) in close contact with persons in groups at high risk (See the NGC summary (1) Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). (2) Update: influenza activity -- United States and worldwide, May 22-September 3, 2005, and 2005-06 season vaccination recommendations. (3) High levels of adamantane resistance among influenza A (H3N2) viruses and interim guidelines for use of antiviral agents --- United States, 2005--06 influenza season). In addition, healthy children aged 6-23 months and close contacts of healthy children aged 0-5 months are recommended to receive influenza vaccine because children in this age group are at substantially increased risk for influenza-related hospitalizations. For healthy, nonpregnant persons aged 5-49 years, the intranasally administered, live, attenuated influenza vaccine (LAIV) is an acceptable alternative to the intramuscular trivalent inactivated influenza vaccine (TIV). (See the NGC summary (1) Prevention and control of influenza: recommendations of the Advisory Committee on Immunization Practices (ACIP). (2) Update: influenza activity -- United States and worldwide, May 22-September 3, 2005, and 2005-06 season vaccination recommendations. (3) High levels of adamantane resistance among influenza A (H3N2) viruses and interim guidelines for use of antiviral agents --- United States, 2005--06 influenza season). Children receiving TIV should be administered an age-appropriate dosage (0.25 mL for children aged 6-35 months or 0.5 mL for children aged ≥3 years). Children aged ≤8 years who are receiving influenza vaccine for the first time should receive 2 doses (separated by at least 4 weeks for TIV and at least 6 weeks for LAIV).
9. Hepatitis A vaccine (HepA). HepA is recommended for all children at age 1 year (i.e., 12-23 months). The 2 doses in the series should be administered at least 6 months apart. States, counties, and communities with existing HepA vaccination programs for children aged 2-18 years are encouraged to maintain these programs. In these areas, new efforts focused on routine vaccination of children aged 1 year should enhance, not replace, ongoing programs directed at a broader population of children. HepA is also recommended for certain high risk groups.

TABLE. Catch-up immunization schedule for children and adolescents who start late or who are >1 month behind, by age group, vaccine, and dosage interval -- United States, 2006

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the chart appropriate for the child's age.

Catch-up Schedule for Children Aged 4 Months-6 Years					
Vaccine	Minimum age for dose 1	Minimum interval between doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
Diphtheria, Tetanus, Pertussis	6 weeks	4 weeks	4 weeks	6 months	6 months[1]
Inactivated Poliovirus	6 weeks	4 weeks	4 weeks	4 weeks[2]	
Hepatitis B[3]	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Measles, Mumps, Rubella	12 months	4 weeks[4]			
Varicella	12 months				
Haemophilus influenza type b[5]	6 weeks	4 weeks if first dose administered at age <12 months 8 weeks (as final dose) if first dose administered at age 12–14 months No further doses needed if first dose administered at age ≥15 months	4 weeks[6] if current age <12 months 8 weeks (as final dose)[6] if current age ≥12 months and second dose administered at age <15 months No further doses needed if previous dose administered at age ≥15 months	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal[7]	6 weeks	4 weeks if first dose	4 weeks if current age	8 weeks (as final dose)	

Catch-up Schedule for Children Aged 4 Months-6 Years					
Vaccine	Minimum age for dose 1	Minimum interval between doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
		administered at age <12 months and current age <24 months 8 weeks (as final dose) if first dose administered at age ≥12 months or current age 24–59 months No further doses needed for healthy children if first dose administered at age ≥24 months	<12 months 8 weeks (as final dose) if current age ≥12 months No further doses needed for healthy children if previous dose administered at age ≥24 months	This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	

Catch-up Schedule for Children Aged 7-18 Years			
Vaccine	Minimum interval between doses		
	Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Booster Dose
Tetanus, Diphtheria[8]	4 weeks	6 months	6 months if first dose administered at age <12 months and current age <11 years; otherwise 5 years
Inactivated Poliovirus[9]	4 weeks	4 weeks	IPV[2, 9]
Hepatitis B	4 weeks	8 weeks (and 16 weeks after first dose)	
Measles, Mumps,	4 weeks		

Catch-up Schedule for Children Aged 7-18 Years			
Vaccine	Minimum interval between doses		
	Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Booster Dose
Rubella			
Varicella[10]	4 weeks		

Note: A vaccine series does not require restarting, regardless of the time that has elapsed between doses.

1. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP): The fifth dose is not necessary if the fourth dose was given after the fourth birthday.
2. Inactivated polio vaccine (IPV): For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age ≥4 years. If both OPV and IPV were administered as part of a series, a total of 4 doses should be given, regardless of the child's current age.
3. Hepatitis B vaccine (HepB): Administer the 3-dose series to all persons <19 years of age if they were not previously vaccinated.
4. Measles, mumps, and rubella vaccine (MMR): The second dose of MMR is recommended routinely at age 4-6 years, but may be given earlier if desired.
5. Haemophilus influenzae type b (Hib) conjugate vaccine: Vaccine is not generally recommended for children aged ≥5 years.
6. Hib: If current age is <12 months and the first 2 doses were PRP-OMP (PedvaxHIB® or ComVax® [Merck]), the third (and final) dose should be given at age 12-15 months and at least 8 weeks after the second dose.
7. Pneumococcal conjugate vaccine (PCV): Vaccine is not generally recommended for children aged ≥5 years.
8. Td: Tdap adolescent preparation may be substituted for any dose in a primary catch-up series or as a booster if age appropriate for Tdap. A five-year interval from the last Td dose is encouraged when Tdap is used as a booster dose. See ACIP recommendations for further information.
9. IPV: Vaccine is not generally recommended for persons aged ≥18 years.
10. Varicella vaccine (VAR): Administer the 2-dose series to all susceptible adolescents aged ≥13 years.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is not specifically stated for each recommendation.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

- Effective and age-appropriate administration of vaccines to children and adolescents
- Decline in vaccine-preventable diseases among children and adolescents

Subgroups Most Likely to Benefit

Influenza vaccine may be most beneficial for:

- Children aged ≥6 months with certain risk factors (including but not limited to asthma, cardiac disease, sickle cell disease, human immunodeficiency virus [HIV], diabetes, and conditions that can compromise respiratory function or handling of respiratory secretions or that can increase the risk for aspiration), health-care workers, and other persons (including household members) in close contact with persons in groups at high risk
- Healthy children aged 6-23 months and close contacts of healthy children aged 0-5 months because children in this age group are at substantially increased risk for influenza-related hospitalizations

POTENTIAL HARMS

Adverse reactions to vaccines

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the U.S. Food and Drug Administration (FDA). Providers should consult the respective Advisory Committee on Immunization Practices (ACIP) statements for detailed recommendations.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

An implementation strategy was not provided.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Staying Healthy

IOM DOMAIN

Effectiveness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

American Academy of Pediatrics, Committee on Infectious Disease. Recommended childhood and adolescent immunization schedule--United States, 2006. Pediatrics 2006 Jan;117(1):239-40. PubMed

Centers for Disease Control and Prevention (CDC). Recommended childhood and adolescent immunization schedule -- United States, 2006. MMWR Morb Mortal Wkly Rep 2006 Jan 6;54(51&52):Q1-4. [5 references]

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2004 Apr 30 (revised 2006 Jan)

GUIDELINE DEVELOPER(S)

American Academy of Family Physicians - Medical Specialty Society
American Academy of Pediatrics - Medical Specialty Society
Centers for Disease Control and Prevention - Federal Government Agency [U.S.]

SOURCE(S) OF FUNDING

United States Government

GUIDELINE COMMITTEE

Not stated

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Not stated

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

This guideline updates a previous version: Recommended childhood and adolescent immunization schedule - United States. MMWR Morb Mortal Wkly Rep 2005 Jan 7;53(51):Q1-3.

Recommended childhood and adolescent immunization schedule--United States, 2005. Pediatrics 2005 Jan;115(1):182.

GUIDELINE AVAILABILITY

Electronic copies: Available from the Centers for Disease Control and Prevention (CDC) Web site:

- HTML Format
- Portable Document Format (PDF)

Electronic copies: Also available from the American Academy of Pediatrics Policy Web site.

Print copies: Available from the Centers for Disease Control and Prevention, MMWR, Atlanta, GA 30333. Additional copies can be purchased from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402-9325; (202) 783-3238.

AVAILABILITY OF COMPANION DOCUMENTS

None available

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on February 25, 2004. This summary was updated by ECRI on October 20, 2004 after the Centers for Disease Control and Prevention (CDC) issued interim recommendations in response to the shortage of influenza vaccine. This summary was updated again by ECRI on January 27, 2005, and on January 19, 2006.

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